CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID
DISPARITY AND EQUITY
TECHNICAL ADVISORY COMMITTEE MEETING

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Via Videoconference
May 3, 2023
Commencing at 1:00 p.m.

Tiffany Felts, CVR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Jordan Burke, TAC Chair

Julia Richerson

Wanda Figueroa Peralta

Catrena Bowman

Patricia Bautista-Cervera

Marcus Ray

Kiesha Curry

Jeanine Lubuya

Elaine Wilson

Roger Cleveland

MS. SHEETS: Good morning, everyone. This is Kelli Sheets with DMS. I will be hosting your meeting today. We will give it a few more minutes. I only have a couple of board members on right now. So we will give it a couple more minutes.

MR. BURKE: Hello.

MS. SHEETS: Good morning, or I'm sorry, good afternoon. We will give it just a few more minutes as we only have a couple of TAC members on right now.

Okay. Again, this is Kelli Sheets with DMS. I am hosting your meeting today. It's very good to have you all on. I currently believe we only have four TAC members on, and I just want to make sure -- I have Julia Richerson, Jordan Burke, Patricia Bautista-Cervera, and Roger Cleveland. Have I missed anyone?

(No response.)

MS. SHEETS: Okay. That means we do not have a quorum. So you will not be able to vote on anything today. You can go ahead and start the meeting, Jordan, if you like.

MR. BURKE: Okay.

MS. SHEETS: I can update you if we do have another member -- another couple of members join after the meeting gets going.

MR. BURKE: Okay. Welcome, everyone. I hope everyone's doing well today. If Deputy Commissioner Hoffmann is available to say hello to everyone, that would be great.

MS. HOFFMANN: I am. So good morning -- or good afternoon. My name is Leslie Hoffmann. I'm the Deputy Commissioner for the Department for Medicaid Services, and I proudly serve as one of Medicaid's racial and health equity champions. And I'd just like to welcome everyone that's participating today for our health Disparity and Equity TAC of May -- I cannot believe it's May of 2023.

MR. BURKE: Great. A couple of things, if you look at the agenda, it's fairly similar to last time. We had just a couple of things to touch on, it seemed like, from most of the old business, and ideally, we will try to hit those quickly and move through some things. If we're able to get a quorum, we will try to finally

approve the minutes from last meeting, and I'm not sure if we'll have to also approve the meeting minutes from the one before that, as well.

MS. SHEETS: Yes, you will. If you get a quorum, you will need to approve those, as well.

MR. BURKE: Okay, so I'm getting a list. Hopefully, we get some more people today, and then we will need to vote on chairs, as well.

As far as old business, on immunization fee schedule updates, I think it was Justin Dearinger last time. The one question I had, they were going to look at reimbursement rates that privatize and seeing what the differences are between the private reimbursement and the Medicaid reimbursement to see if there was a way to match those. And also other potential solutions to help with the issue that Dr. Richerson brought up about clinics that are involved with BFC being able to get vaccines to their patients if there's an update on that.

MS. SHEETS: I don't think Justin is on, Jordan, but --

MR. DEARINGER: I'm here.

MS. SHEETS: I'm sorry.

MR. DEARINGER: Okay.

MS. SHEETS: Okay. Thanks, Justin.

MR. DEARINGER: Yep, no problem. I'm going to have a short presentation. I believe Erica Davis has a short presentation on immunization fee schedule updates. We were able to do two different projects. One project looked at some rates or different parts of immunizations across the private sector, and we were able to look at some other states, as well. So if you all have any additional questions after Erica's presentation, we can discuss that.

At this time, with the fee schedules that we've updated over the last couple of years, I believe our rates are favorable with other states' rates at this time, but we will continue to review that to see if there is any additional updates that we can provide. But with that, I'll let Erica go ahead and give a short presentation.

MS. DAVIS: Thank you, Justin. I am not able to see how to start this slideshow, so I'm just going to go through these as best as I can. Hopefully, you are able to see the presentation.

MR. BURKE: Yeah, we can see it.

MR. DEARINGER: Yes.

MS. DAVIS: Great. So the first thing I wanted to do was a little bit of an update on the immunization rates. Due to COVID, we had a lot of children that weren't getting in to see their doctor at all. And if you are interested in seeing some of the county-by-county rates, the immunization branch in the Department of Public Health does publish their annual school survey report, and you can actually see the numbers by each school and also by the grades. They do have to pull some things out, like highlights for the kindergarten cohort, sixth grade, and high school, so if you are interested in seeing some of these things -- the breakdown by county.

Also, there are a couple of opportunities for getting some more exposure

for immunization uptake, and those are through the Immunization Summits throughout Kentucky. So you can see there's one coming up next month or next week is the immunization summit in Lexington, and then there's an event in eastern Kentucky in Morehead and another in western Kentucky in Owensboro. These sites will be sent to you, as well. So I know I'm going pretty fast.

And then, the topic at hand was the immunization fee schedule. What we have found out is that the fee schedule for immunizations is included in the preventive fee schedule and also the physician fee schedule. And historically, we were only adding new codes and deleting old codes. And any update for an existing code was only done if their immunization was on April 1st of 2022. As Justin touched on, we are reviewing all of our fee schedules, and I know this is really difficult to read, but what is of most concern, I believe, for everyone in this TAC is the immunization rates, which is what is highlighted here in the yellow. And these are the last time

that rate was revised. So this is just a little snippet of all the immunization codes that are available. And you see some of those -- it's been quite a while since these have been updated.

We do also have from CMS, and if this will open -- CMS provides what the private cost is for all of their vaccines, and they do this annually. So it does allow us to see what the private cost is to make sure that we are providing a reimbursement that covers the actual cost of the vaccine itself. So we are looking at all of that information. In addition to that, we are looking at what our surrounding states are doing, and this is just an example. This is for the nonavalent HPV vaccine. So we have what CMS says is the private sector cost, and then we looked at what Kentucky is reimbursing, and Indiana, Ohio, Tennessee, and we are looking at various surrounding states to make sure that one, we are in line with what other states are doing, but also that we are fully covering the cost of that vaccine.

We don't have that finished yet because that is an ongoing project, but that is something that we are doing. We are looking at each one of those vaccine codes, and if you have any questions about that while we are ongoing with that process, these are the contacts. You can contact Justin or myself. Eddie is the supervisor over the fee schedules, and Tom Young is actually the Medicaid specialist who puts in all of those codes, and he can provide some of that historical information as well.

MR. BURKE: Thank you, Erica. I appreciate that. And one thing to consider, is anywhere -- we have anywhere from 10 to 20 providers that provide e-mails or contacts related to different codes, asking for codes to be added, removed, altered, or for fees to be increased. One of the first things we look at specifically with vaccines is, are we ensuring that we're covering the cost of the vaccine? We already have codes that cover the administration or the reimbursement for the administration of vaccines, but we look to make sure that our

reimbursement covers the actual cost of the vaccine. So anytime you get a complaint or issue with a particular vaccine, we research that to see what DMS -- what the current costs nationwide of that vaccine is. We also look at supply issues, and we look at other states to make sure that we are providing enough reimbursement to cover the cost of it. So that's an ongoing process that we've been doing that anytime a provider has an issue with a specific code, we always review that to make sure that we are in line with what they need to be able to provide that service.

So at this time, we believe all of those codes are up to date. We encourage any provider that's having issues to reach out to us. But again, like Ms. Davis noted, we are in the middle of -- or actually just began the large process of going through all codes on all of our fee schedules to ensure accuracy and also to look at pricing and to make sure that those are all up-to-date.

MR. DEARINGER: Dr. Richerson, I know this is something that you had, you know,

discussions in the past. Based on that, it looks like there were some fee schedules that were not updated for over a decade that seems to be updated more recently. Do you think that from the clinics, are there people that, you know, who run offices, like those who have struggled, do you think it's a thing where even though they updated things that are covered -- or particularly them not being aware that they finally were updated and them not, you know, recognizing that?

MS. RICHERSON: Yeah, I think so. I would like -- if you could send us -- so Justin, did you say on the current fee schedule they are already updated, or you are still working on that update? Because I want to take whatever is updated to the practices in Louisville -- the updated costs. Do they need to -- do they cover yours or updated payments? Do they cover your costs? Because, you know, everyone pays something different for vaccines. So is that list ready, Justin, for me to take to the -- .

MR. DEARINGER: Yes. It's ready. Of course, again, we're going through that currently, but as of right now, that's the list that we're currently paying off of, so that should be updated. As far as, you know, as far as I can give you because even when the project is over we are constantly updating and upgrading codes and prices, so that's kind of a never-ending process. There will never be a point where I say this is finished because we are always, you know, looking at -- vaccines are a big part of that. We'll always have at least a couple of providers that are asking about certain codes, but what's online right now should be -- would be what you can take to them and have them look at or view.

You know, again, we're not always able to meet the exact cost that a provider is paying. There are times when a provider may be getting a vaccine that's overpriced or that just as it meets, you know, if it falls too high above private practice prices based on DMS, or that it's just way out of line with other states, then we always have

discussions with those providers on some contacts with some other providers to get vaccines from different sources that are more cost-effective.

MS. RICHERSON: So this currently is the online -- the fee schedule? They have all been updated recently -- they match the DMS list? As you know, they've all been looked at and match the DMS list as far as you can tell?

MR. DEARINGER: As far as I can tell. Again, some of the codes haven't been -- we haven't been asked to update -- some of the codes haven't changed or varied that much from what DMS has put out most recently, so as of right now, that's the current --

MS. RICHERSON: Okay.

MR. DEARINGER: -- fee schedule. Yes.

MS. RICHERSON: So I think we have asked for them to be updated. Over the last couple of meetings, we have said, please update all the immunization codes to match at least the DMS cost list.

MS. DAVIS: And, Dr. Richerson, we

are doing that. We are in the process -- like Justin said, we've just started because we're looking at all of the fee schedules. But for the immunizations, that is the project that I'm taking on, so I will definitely look through each one of those codes and make sure that it is matching what DMS has put out there, but -- and again, you will get this information via e-mail. Kelli will send it out to the TAC, but if you get that DMS list and it doesn't match what some of the providers are paying, that would be helpful for me to have that information if that's --

MS. RICHERSON: I didn't know whether to take the DMS list or y'all send -- it sounds like I should take the DMS list and work from there.

MS. DAVIS: Yes, but we're actually reimbursing for -- right now, it is the fee schedule that it is on.

MR. DEARINGER: Right.

MS. DAVIS: But that DMS list is not meeting the cost that some of the providers are actually paying, and that would be

helpful for us to know.

MR. BURKE: Great. Thank you. And you'll e-mail that out. Great, and again, this is -- we identified this as an equity issue, right? So we really want children to receive their vaccines. We identified a barrier, meaning that it is an administrative burden that's too expensive for some practices to participate in. They choose to send their patients elsewhere for their vaccines. But if they were to be paid at a rate that allowed them to use what's in the refrigerator, that would decrease barriers for vaccines and decrease health disparity, so this is a really important disparity issue.

So I will take the list -- Erica, when you send it out, I will talk to a few practices across the state and see if it meets people's expectations, so thank you.

MS. DAVIS: One of the things that I wanted to point out before we moved on also is to take a look at the VFC program. There are some administratively burdensome areas of VFC; however, I think it's important for

the Disparity TAC, in particular, to look at the information, and the reasons why those administratively burdensome sanctions are in place is one of the biggest reasons --

MS. RICHERSON: This is a little more -- the failure rate of vaccines that are not properly refrigerated or handled. That's something that, you know, that's one of the reasons why we have VFC. It may be a little more burdensome, but for us providing substandard vaccines that may not work to children is something that is not really acceptable, and that's one of the things that (indiscernible) children and where they get their vaccines. And some information that would be very good and helpful for everybody on the TAC to be able to look at and understand is the failure rates on those vaccines and VFC programs compared to the failure rates of those vaccines in other areas.

MR. BURKE: Yeah. Yeah, that's fair. The next item was just a quick one, too. I think it was just in as a placeholder. The transportation access. We had talked about

more people getting access through the relaxed laws on people who had their own vehicle, and I had asked the question, do we know what that means for children with parents of the vehicle, or if someone like lives in the household the vehicle is at and how that will impact them? Do we know anything else about that?

MS. HOFFMANN: That requires a demonstrated regulation change. That administration regulation is still in the promulgation process. I tried to get an estimated date -- I don't really have that in front of me. It will be filed at some point this year, but it's still kind of going through the process. One of the longest processes with the administrative regulation changes is receiving input from stakeholders, and that's where this administrative regulation is in the process. We have edited and accepted the new waiver that has this language in it that allows us to do this from DMS.

We've also updated the contractor that we contract with to provide

nonemergency Medicaid transportation. And that administrative regulation has been drafted and kind of finalized on our end from DMS, and we are currently getting stakeholder input at this point in the process. Once that stakeholder input is gathered from all sides, we review that to see if we need to make any changes, and then we send that to the secretaries office to go through the Office of Policy and Budget, Office of Legal Services, and secretary review before that is filed with the legislative research commission. And I believe there may be someone from DMS that has a short presentation on it. If not, I can discuss it.

MR. BURKE: Okay.

MS. HOFFMANN: Is there anyone here -- anybody on that --

MS. ROEHRIG: Hey, Jordan, this is Rachael, and I work with DMS in the Quality and Population Health Division. We are going to have a presentation prepared and ready for the next TAC meeting to go over transportation services in more detail.

MR. BURKE: Okay, that sounds good.

MS. ROEHRIG: I can provide just a little bit of what we have proposed and what we have accepted in the waiver. You know, one of the issues that we've had with individuals receiving the services -- there's a lot of different issues that we've identified while researching the no-show list and other methods, but one of those issues is the vehicle in the households policy. That policy stated and currently states that if an individual lives in a household where there is a vehicle, then they are not allowed to have those services, and the transportation services are not accessible for them unless they have a mechanic statement saying that that vehicle is not in use. As you all know and are aware, a lot of times, families or individuals will be forced to live in a household that is just, you know, allowing them housing, and it doesn't really have anything to do with their situation. And so, taking that into account, we've altered that disqualification to say that the

vehicle has to be in the individual's name. So that individual has to actually own, on paper, a vehicle, and it doesn't have anything to do with the household that they live in necessarily.

That requirement also has the caveat that they may be waived from that disqualification, again, if they provide a mechanic statement saying that the vehicle is not operational or if they provide a physician's statement saying that the vehicle is not operable by that individual, meaning that individual has some kind of physical condition where they're unable to drive. So we feel like that's going to open it up quite a bit to a lot of different individuals that are living in households strictly for housing. It doesn't have anything to do with the economic stay at that time.

MR. BURKE: Yeah, and I think we had tested that last time. The only question was, you know, regarding, for instance, if a child lives at home with their mother and, you know, grandparent or something like

that. And the grandparent owns the car but has to work, and the parent, you know, is at home during the day and doesn't have access to their own vehicle to drive the kid, you know? Is there any specific --

MS. ROEHRIG: Yes. I'm glad you brought that up. So if an individual is the legal guardian of a recipient that's under the age of 18, then that individual would be treated just like the individual that had the vehicle. So if that individual has a vehicle in their name, they would need to get one of the two exceptions that I just mentioned. However, there's a third exception for those individuals. They're able to send in a waiver request that waives that requirement for two weeks while we look at an exemption. Say, you know, they work during those hours or something like that. Then they can send in a waiver request to be approved and looked at or automatically given two weeks. Within that two weeks, we will look at their reasons why they're not able to use that vehicle for that transportation, and they can be waived for

that, as well.

MR. BURKE: That sounds like a presentation that will be for the next meeting. I will move on to the community health workers --

MS. RICHERSON: I'm sorry, Jordan. Can I just say one more thing about transportation? I think it's great that you all are looking at the regulatory issues and exemptions and all of that stuff. I think another angle that we talked about before is the company's you're contracting with, and the lack of responsiveness that providers and MCOs are feeling when -- I had somebody send me an e-mail detailing great detail that the company that you are contracting with is unresponsive, not responding to phone calls, canceling appointments, and that's what we hear from patients is I thought it was scheduled and then nobody showed up.

So I think in addition to the regulatory stuff, we need to figure out a process of how do we assess what's going on with these contractors? Because I don't

think you are probably getting all of that information that you would like to have because not only are there challenges from administrative issues, there's just challenges with the contractors and their responsiveness. So we should at least come up with a plan to look at that more deeply because that's an ongoing issue that's been around for quite some time, and I think we can address it effectively.

MR. DEARINGER: Thank you. I'm glad you brought that up, too. That was another part of the things that we found with no-shows is individuals having issues with their transportation provider. We've started requesting weekly reports. The transportation contractors have detailed logs of when the call came in, when the appointment was scheduled, when individuals were picked up, and when they were returned. They have times and summaries of each instance, and so we do receive calls of failures or other issues that we look into each individual call.

However, there is an issue with the

no response time, particularly on the return trip. We haven't found a significant issue where people are not able to get scheduled or where people aren't showing up a lot. I know that does probably happen, but we haven't found that to be a significant issue. The pickup home from the appointment, we are finding some longer-than-expected wait times, so we have a couple of different projects that we're looking at to increase the availability of drivers and contractors. And so we are working on that issue, as well.

MS. RICHERSON: And then how can members directly provide feedback? Is there something online or a phone number or something so you can hear directly from the Medicaid members?

MR. DEARINGER: We're currently contracted by the Department for Transportation, and they have a review system set up where the individual contacts them at that number. If the individual doesn't satisfactorily get an answer that assists them and helps them, they can always

contact us here in the department. They can either go through the Omnibus office, that will direct those questions to us, or they can contact us directly. And I will put the providers or our administrator's name and e-mail contact in the chat.

MR. BURKE: Okay. Dr. Richerson, are you trying to -- I mean, obviously, it sounds like assess how the patients themselves are able to respond or rate, almost like Uber rating or something like that to their rides that are supposed to be coming. Is that kind of like what you are trying to assess is in place, and if not, a way to implement something that they can get better feedback on how well that transportation is actually being delivered to them?

MS. RICHERSON: Correct. I think learning information directly from the companies is great, but what you need to be able to hear directly from the families that are impacted is when they can't get to the doctor because of transportation issues.

MR. DEARINGER: Yeah. The Department

for Transportation has a system set up in place to have a contact line. They have an access database that puts all of those complaints in place, and they are required to respond to and investigate each complaint that they receive. And we get reports from those and what each individual complaint was. I think those are monthly.

MS. RICHERSON: Can you get us that contact information, too, so we can get that to families?

MR. DEARINGER: I will for sure, yes.

MR. BURKE: Any other things for that topic?

The community health workers: Last time, we were just kind of wondering, I think, I'm not sure if that will be yet, but I think the date was around this time. I don't know if that's had approval. Is that something we would be able to read about or see at this point?

MS. PARKER: This is Angie Parker with Medicaid, and I can share that the state plan amendment for community health workers was approved. We are currently

working on the regulation, and it will be effective July 1st, 2023. We are also working with Justin's team to come up with an FAQ as to how all of that will work, so we can share that, as well, once we have that finalized.

MR. BURKE: Okay.

MS. RICHERSON: And I couldn't tell -- I read some of the information. I couldn't tell, are there any limitations in the type of community health workers? So, for example, isn't it limited to people with chronic illness? Or can it be a child with medical complexity or social complexity? Do any of those count, or are there limitations in the type of workers?

MS. PARKER: No, not to what you are specifically -- you know, if somebody needs help with transportation or finding transportation, they can do that. As an example, they don't have to have a complex medical disease.

MR. BURKE: Dr. Richerson, where did you find that to read anything about that?

MS. RICHERSON: I received an e-mail

from the community health worker state organization, which I can forward over.

MS. PARKER: Yes. This past week or last week, I did a presentation for the Community Health Workers Organization. It was very high level, and there were some questions that came out of that that we are -- I had mentioned that we are working on making sure that we get those answered in an FAQ to provide to everyone.

MR. BURKE: Cool. Okay. Any other things regarding that topic?

MS. RICHERSON: You said July 1st, 2023?

MS. PARKER: Yes, ma'am.

MS. RICHERSON: Okay, great.

MR. BURKE: Okay. So I'm trying to move through things quick because we're supposed to have a presentation from 2 to 2:45 about the MIC, so I'm trying to cover some of the earlier topics.

For subspecialty access, we mentioned -- last time, I had just brought up the question, you know, do we have any good aggregate data regarding how much

out-of-state medical care is being provided? Whether it be for certain subspecialty encounters, we had talked about single peace agreements and things like that, but I think some people were going to look into if there were any -- if there's any tracking going on already, and if any new things have been done to see what was really happening outside of our own state for our own patients?

MR. DEARINGER: This is Justin Dearinger again. I don't remember who exactly was on that project; however, I know that we had asked for a report of all of the out-of-state funds -- out-of-state providers that were being used to provide services and what services those were, and what dollar amounts. Of course, a majority of that will be single case agreements and long-term care, usually solutions for individuals with highly specialized needs, but I don't think we received that report yet. It should be ready by the next meeting.

MR. BURKE: Okay. All right. Kind of getting into things we didn't have as

much time to talk about last time. Dr. Richerson, you'll be really helpful in these topics because I think these were some of the things we had listed that you might be able to help clarify more on, but we did get to touch a little bit on interpreter Medicaid coverage. I can't remember who exactly had brought up the trend of trying to figure out a better way for those services, which are often essentially required, but, you know, in this part of the state, it's not something that I use as much, but I'm sure it's in need. So I'm not sure exactly from an insurance standpoint, things like that, how are things currently being covered, and what kind of goals are we looking for in order to help better serve the communities where the patients are more prevalent?

MS. RICHERSON: Well, I'll just say that there are how many MCOs? Five? And there are five different ways to access interpreters, and most of them are very cumbersome. I've been working really hard directly with the MCOs and different staff

people to try to streamline to figure out what the numbers are. And so it's still not accessible. Most subspecialists aren't -- often still don't use outside interpreters because of this. So I think we just keep it on the agenda unless somebody else has a way to figure out most effectively where we are -- what's the status and how we can test it.

MR. BURKE: Now, does anyone from Medicaid -- has this been looked at elsewhere, or are there any plans to expand or I guess make one solution of how to implement translation services for patients?

MR. DEARINGER: Interpreter services have been something that had been brought to our attention just recently as far as availability and access. I think that's something that we are going to discuss and hopefully implement some policy. I know we've got one team in particular working on that, but it's something that we have to, you know, each MCO is allowed to have it's own -- it's own procedure for interpreter services. And so we're going to look at different models and do some training on

that with each MCO to see if we can try to streamline that a little bit more. And at the very least, have some information sent out by the MCOs on how to request an interpreter if one is needed.

MS. RICHERSON: Just real quick as an example, sometimes the phone tree is up to eight to ten minutes before you even get to be able to ask for an interpreter. So that's just an example of the cumbersomeness of the situation, and there's -- I think it's just an oversight. I don't think anybody wants to put those barriers, but it takes some work to streamline stuff like that, so --

MR. BURKE: Yeah, for sure. When I worked in Florida, it was obviously something that we used far more. I don't know anything behind the scenes as far as coverage or anything like that -- what was going on, but I mean, it's definitely a service that there's no doubt, it's a requirement for medical care for a large portion of those patients.

Okay. For telehealth:

Dr. Richerson, what was your -- when you had put that on the agenda prior, what kind of questions were you trying to bring up or had been mentioned that brought that as a topic or possible talking point?

MS. RICHERSON: I don't think that was my topic. That was just a carryover that somebody had. I would have to go back and look and see -- oh, I know what it was. It was using telehealth to increase access to care in different ways, but we can take that back to the old minutes at some point.

MR. BURKE: Yeah.

MS. RICHERSON: I think it came up with the discussion with (indiscernible) at one point, so --

MR. BURKE: Okay. I guess from my own perspective, I can see how it could be useful for even -- for certain subspecialties and things for patients in different areas and things. I know that Pikeville has a facility that I think for pediatrics were a couple of different subspecialty clinicians, and at UK, their patients can come there and face time with

subspecialists. I don't know if that's as prevalent in other areas or something that's being looked at being expanded to increase subspecialty access, but it seems like a decent option. We can cut down on commute times for patients if they are able to do it. You know, how effective that can be, I think, is a little different depending on the subspecialty.

Is that a raised hand by Justin?

MR. DEARINGER: Yeah, I wanted to say on the telehealth, we, of course, as you all know, during the pandemic we expanded access via telehealth for all provider types. Additionally, we created some administrative regulations that were for that pandemic specifically to get us through until everybody was able to go back to the office. Due to the success of those regulations and also the ability to expand access to individuals needing care, we have made -- those regulations are now permanent.

Those codes are permanent. Telehealth is still accessible and will continue to be accessible to all

individuals. We'll be able to use all provider types. We'll be able to use telehealth. There are very few restrictions due to federal law or statute that still require face-to-face, but the majority of all services are to be able to be provided telehealth. Things like these continued regulations and coding changes are permanent. So those individuals now have access via telehealth to almost all services that they would need.

MS. RICHERSON: Jordan, I know it was, like you said, under the discussion with subspecialty access. I know it was because that's such a disparity issue, access to subspecialty care. What could Medicare do to stimulate more access? Having no regulation against it is one thing. Having opportunities to promote it maybe, and expand it while working with the MCOs is an opportunity.

MR. OWEN: This is Stuart Owen with WellCare. If I can just chat -- MCO support, even before the pandemic, Kentucky Medicaid -- kudos to them for very

progressive coverage of telehealth. Very progressive, even more so during the pandemic, Kentucky's been pretty much the leader, and all the MCOs support that. And we tracked care delivered through telehealth, and it just blew up during the pandemic, and rightfully so. It's a good lesson for everybody that it's a great, you know, weapon for access to care. And I think it's dropped a little bit, but not a whole lot, but a lot of providers are aware of that, and I mean all MCOs support it. So it's kind of one of the good things of the pandemic is we realize, hey, you know, it's definitely hastened the use of telehealth for health care.

MS. RICHERSON: Yeah. I just don't think, Stuart, that there's a single subspecialty that any of my patients can access through telehealth, for example, so those opportunities are still available.

MR. OWEN: Okay. Well, I know we all promote it. So I mean, I think all the MCOs are definitely supportive and open to that.

MR. BURKE: Is there a way -- I guess

I don't know the best way that anyone would go about it, but to promote to the clinics that provide the subspecialty care to make appointments specifically for telehealth? Or somehow, when referrals are in place, that it's an option that they can be put in as a telehealth encounter? I mean, I know that I have some spaces for endocrinology and things like that that will be listed as telehealth, but I know that there's, you know, there's more subspecialties than that that patients see. And obviously, exams are very valuable, but that history is oftentimes the most important part, and if, you know, there's a historical factor that makes that exam that much more necessary, then by all means, yes, they'll be able to request that visit that much sooner or try to get someone scheduled in person much sooner, but I don't know a good way that we could potentially go about encouraging subspecialty providers to maybe make those scheduling happen more frequently. I don't know, but that's probably something to think about as far as ideas to encourage to help

with access.

MR. OWEN: Yeah. I mean, I agree. That's a great point. I know we've had webinars with providers, you know, at WellCare, but not targeted. It's open with everybody promoting telehealth and talking about telehealth, but it wasn't targeted like you're talking about with subspecialties. It's definitely something we could all take back, and I don't know. Of course, the provider has to be willing to -- I don't know. Some of them don't like telehealth. I mean, that's a possibility. I don't know, but they would have to be willing to do it, as well. But that's definitely a good thing we can take that back and talk to our staff that works with providers about that.

MR. BURKE: Yeah. I mean, I totally understand. I much prefer an in-person appointment myself as a provider, so I totally understand that. But my patients are all right here. I don't have any patients a few hours away waiting to see me, either.

So for -- I think last time we had mentioned -- someone had mentioned potentially Lesa Dennis, I think, was somebody that used to work with Dr. (indiscernible) and would maybe have more information regarding the immigrant health workgroup.

MS. HOFFMANN: Jordan, this is Leslie. I did follow up with that. She wasn't familiar with that, so she reached out to the previous commissioner's job, and then we ended up getting to meet with her on a call and talk to her. She said she wasn't sure where that report was coming from. She thought maybe it was public health. I'm not just saying it's public health to get it off of our agenda. I'm just saying she couldn't recall that specific conversation. Of course, she's now retired and working elsewhere in the state, so I just wanted to share that she wasn't able to track that down through Lesa or the commissioner's job unless it's something like public health that they might have access to.

MR. BURKE: Okay. Is anyone aware of

when this was initially brought up, even without that information available? What was the sort of thing that this was really targeted at, or do you know?

MS. HOFFMANN: I think it was just numbers and demographics, I think, and somebody apparently said in the transcript -- because I even have the transcript pulled trying to track it back down, but nobody seems to remember what exactly we were talking about or what specific report it was. So the commissioner said she's more than willing -- of course, she's not commissioner anymore, but she said she's more than willing to help us, but she's not familiar with what we were talking about. So that's where we've landed right now.

MS. RICHERSON: Owensboro -- she participated in it, too.

MS. HOFFMANN: Who? I'm sorry --

MS. RICHERSON: The TAC member that's from Owensboro. She was the one who had participated in that discussion.

MS. HOFFMANN: Okay.

MR. BURKE: I don't know who that is.

It's not at the top of my head.

MS. RICHERSON: I'm just going to look -- I was going to say, to consummate on this call for Medicaid, maybe follow-up. Does anybody on the call know who the member was from Owensboro?

MS. SHEETS: I can certainly look. This is Kelli.

MR. BURKE: Yeah, can you reach out --

MS. SHEETS: I can reach out and see and look through our documents. I'm new to this, so I don't know off the top of my head, but I'll certainly look through our documents and see what I can find.

MS. RICHERSON: I think it's Wanda in Owensboro. I think it was Wanda.

MS. SHEETS: I don't know where she's from, but maybe.

MS. RICHERSON: So Kelli can reach out. We'll still keep trying to track it down, and I'm sorry.

MS. HOFFMANN: She's from Owensboro.

MS. SHEETS: Wanda is at River Valley Behavioral Health. I'm guessing it's

probably her.

MR. BURKE: Okay. She's usually, I feel like, at most of the meetings, so if maybe someone can reach out and ask her in between this meeting and the next if she had any specifics that she wanted to discuss from that. Or if she's at the next one we can make sure to bring it up with her to see kind of if there's some specific groups that she's trying to help from the disparities standpoint, and what ways we can maybe try to target that.

For the next item, a clarification on EPSDT visit timing. I think that was a -- I had brought up, and I had looked into that a little further and asked the billing department. Here are some of them from -- Passport had reached out to me, as well, from several months ago, and again, I'm sorry if I forget the name. I wasn't able to actually come across any visits I had where there was an issue as far as billing for well-visits, even if I had been a few days early for, like, the one-month visit or something like that. You know, if it was

like 26 days or, you know, a month and a week, they didn't find anything like that.

The same thing happened with the vaccines on coverage, as long as, you know, it was the six or seven-week-old that did end up getting the two-month vaccines. There didn't end up being an issue as far as our billing department was able to find. And if for some reason something does come up with that, you know, in our clinic, it had been mentioned before. I think it's something that maybe back in the past it was a thing, but it doesn't turn out to be a thing anymore, so that's a great thing to find out.

But it may be something that other providers throughout the state might benefit from knowing, as well. Whether it was our clinic that was unaware of this until I mentioned the issue when it was something that was kind of being pushed as a potential issue, but it sounds like it's something that's been resolved. So good job, Medicaid, for fixing it. We just need to let people know.

And then, juvenile health was something that was just kind of touched on right at the end of the last visit, and I believe that was Dr. Figueroa, as well, who had mentioned that? I think Deputy Commissioner Hoffmann touched quite a bit on it, you know, quickly toward the end. But what kind of issues are facing juvenile health patients that we have is that they're currently not being covered through Medicaid. Or are we trying to extend that out so they are covered?

MS. HOFFMANN: Sorry. I'm trying to get off mute. I can't remember exactly what I said, but I will tell you that we have two bills currently right now. These are correct. These are combined youth that we're taking a look at. They currently would not receive (indiscernible) being an incarcerated member.

So currently right now, we have two bills out there to try to do something very similar to what we asked DMS to cover for the adults. So now we're trying to do that for the children, as well. There's an

omnibus act that comes out -- I think it's going to be effective 2025, or there's an omnibus act of the (indiscernible) is available 2025 to cover some services. Things more like assessments and things like that for juvenile justice, but I wanted to let you know that our movement on our incarceration amendment after three years has finally picked up. We're meeting currently with our DMS folks to figure out how to expand that because a lot of social determinants of health and racial and health equity issues and all of those things that came out in those three years, as well as the juvenile system pieces. So we want to try to start incorporating some of that when we make an amendment to our amendment, for lack of a better word.

So we have an amendment currently at DMS for SUD, and we want to expand that. So we're going to be working with DMS on a weekly basis if that's what I talked about last time. I think it was.

MR. BURKE: Yeah, I believe you touched on similar things last time.

MS. HOFFMANN: Okay.

MR. BURKE: Again, for me, a lot of these topics are things that I'm, you know, myself less familiar with. Someone mentions -- brings something up -- I'm trying to learn, as well.

So I mean, that's good, right? That's also more trying to make sure that those patients, who obviously I'm sure from a health standpoint are not -- it's not the first and foremost thing people are trying to address, but it's all the more important that we are.

Good. We actually got through all the parts under old business. So I'm trying to move forward a little bit. I would actually like to skip to part C if that's okay. I wanted to see if Vivian was on. Is she on today for us?

(No response.)

MR. BURKE: We will see if she's on next time, and I will mention it again. Or if someone else for Medicaid has done any work with that or knows highlights from it? From the most recent Minority Health Report

and wants to share anything?

(No response.)

MR. BURKE: Okay. I can push it to the next one. That's fine. And then, reorganizing, part B, we had talked about the Racial Equity Action Plan. I believe there was supposed to be a quarterly review between our last meeting and this one. I wanted to see if there were any updates or points to touch on from that.

(No response.)

MR. BURKE: Is there --

MS. PARKER: Danita, are you on to go through this?

MS. COULTER: Yes, I'm on. We did have our -- the racial equity core team, we did have our recording update and everything on March the 27th to provide their reports. We, too, have a summary that I can send to the TAC, which is an overview of what each division has done to date. The invitations have been sent to the TAC to participate in those updates because we would like for our stakeholders to participate if interested. We do know that there may be some scheduling

challenges because it is during your times that you may be seeing your patients, but that information is available to share with the TAC. So I can send that to Kelli, and she can forward the summary to you for your review.

MR. BURKE: Yeah, that'd be great. Okay. We have about, I think, five minutes before we were supposed to have our presentation regarding the MIC. Last time -- or was it many more times, I believe it was Leigh Ann Fitzpatrick who was doing the GARE presentation; is that correct?

MS. HOFFMANN: The plan was for Leigh Ann Fitzpatrick to present the GARE presentation, and we were actually going to mention today that we're going to ask you to move that to the next meeting, and I have a good reason.

MR. BURKE: That's fine.

MS. HOFFMANN: One, we are currently right now revising it again, so we really wanted you to have that revision. We just finished with some pretty aggressive stakeholders related to (indiscernible) in

the community. So we wanted to add those things to the tool before we bring it back to you.

She could have been on today. We talked to her this morning, and I thought no because we're right in the middle. It wouldn't make sense to have to do it twice for you. So I think we can go back up to the MIC updates because I think we're going to need a little bit more time for the MIC presentation anyway.

MS. SHEETS: Nick, is that correct? Sorry.

MR. BURKE: Yeah, they were supposed to be on it, too. So I can send a quick e-mail to see if there's been a hold-up with them.

MS. HOFFMANN: It might be the time difference -- just the confusion, too. Jordan, if you want to wait, we can move on, or I can give you some updates on that 1115. I think that's on new business, but I was just going to fill your time.

MR. BURKE: Yeah, sure. Yeah, that works.

MS. BICKERS: Kelli, I just admitted John Whaley. I don't know if that's who we're waiting on or not.

MR. BURKE: Is he the person that will be giving the presentation?

MS. HOFFMANN: Yeah, I will hold then.

MS. SHEETS: Okay.

MR. BURKE: Hey, John.

MR. WHALEY: Nice to see you all. If you want me to come back a little bit later, that works.

MR. BURKE: No. If you're ready to present, we'll go ahead and let you do your thing.

MR. WHALEY: I'm looking to see if Veenu has joined from the Medicaid Innovation Collaborative. She will kick us off, so she may be just a couple more minutes. And while we're waiting, can you just give me a sense of the folks in the room just so I can get a sense of our audience today?

MR. BURKE: Yeah, for sure. Leslie Hoffmann might have a little bit, I think,

of a general overview. I'm Jordan Burke. I'm a pediatrician from eastern Kentucky. I'm the chair for the -- well, depending on a vote once we establish a quorum. For now, I'll be the chair for the Disparity and Equity TAC. We have several different people from all over the state from different areas of health care providers, to people in education. Just trying to finally take a look and address more of the parts of health that are based around social determinants of health and things like that that have been likely somewhat neglected in the past, but trying to hone in on and adjust to help people out now.

MS. HOFFMANN: So John, I think you and I have met before. I'm Leslie Hoffmann. I'm the Deputy Commissioner for Medicaid, and I kind of started out the racial and health initiatives on the Medicaid side. And our cabinet is huge, and each one of our departments within the cabinet are working towards pillars that were addressed for racial and health equity at the cabinet level. So it's not just Medicaid. It's

cabinet level, so we have all kinds of partners that are involved with this one, plus stakeholders, advocates, providers, members, and those kinds of things.

So this is the TAC, what we call in Kentucky a Technical Advisory Committee, and they can make recommendations to the MAC. I know it's a lot of acronyms, but the one I'm used to is the one -- the MAC, the big Medicaid Advisory Council that can make recommendations for the secretary and the government and things like that. That's one of the new ones. We've got about 18 here in Kentucky, and we just added this one and the Persons Returning to Society from Incarceration.

So this is a very big day. I get asked -- we are so lucky to have this kind of TAC for the whole cabinet. So if that kind of helps to set the standard. One of the hugely helpful things I look forward to is a really rich discussion. Do you want to kickoff --

MS. AULAKH: Yeah, sure. Thanks for having us. I'm Veenu Aulakh. I am the

executive director for the Medicaid Innovation Collaborative. I think a couple of months ago, you all heard from my colleague, Chris, who I believe gave background about what the Medicaid Innovation Collaborative is all about. And what we wanted to do today, I thought maybe I would just give a quick overview. Just a reminder of what it is and how the work that John's been doing for us fits into this context.

I don't know, John, if you want to just share a couple of slides? And then, our hope is that John will review the research findings specifically as it relates to Kentucky and hopefully have some conversation with you all about the findings and how it might help impact the work you all are trying to do.

So just as a reminder, the Medicaid Innovation Collaborative, we are nonprofit program part of (indiscernible), focused on the belief that there is an important role that tech-enabled innovations can play to improve on Medicaid. And the next slide.

And this year, we are really focused on social determinants of health. Some of the research that John is going to be sharing is really around talking with individuals in Kentucky about how they think about social needs and how it impacts their health. And that work -- the work that John completed has been fundamental to our entire process. And I'll -- if you want to -- go to the next slide, John.

Basically, our process is started by really deeply understanding consumer beneficiaries' needs and use that to identify what other problems we're trying to solve. And how do we make sure that the solutions that we try to identify are in line with those problems? So the research that you're going to see was really fundamental, and what ended up being our request for information where we put out a call to companies who might have solutions, and excitingly we got 106 solutions that really addressed the social needs. Everything from food insecurity to transportation to navigation. And John will

talk a little bit about how that came out through the research.

Right now, we're in the process and (indiscernible) where we are reviewing the solutions. So tomorrow, we have a consumer advisory board meeting, as well. Many -- a good portion of them are from Kentucky who are looking at the solutions, as well, to make sure that they make sense and help solve the problems that they're trying to address. We are going to have a meeting at the end of May where we are going to highlight from those 106, the top 8 that seem like solutions that we think -- and the advisors, and folks for managed-care organizations, state Medicaid, the consumers, and our experts really believe are ones that could help close the gaps and address some of those needs. And then, the hope is of those solutions, we will be able to partner and contract with managed care organizations and partner with the state to see how we could actually get them tested and piloted and rolled out.

So that was just to give you the

overall context of how this research has been. And so what we wanted to do today was share back that research, which has been critical in shaping this process, but hopefully have some other insights that will be valuable to the work you're doing in Kentucky.

So with that, I'm going to hand it over to John Whaley, who's been really reading this research and ensuring the findings.

MR. WHALEY: Thank you. Thank you, everyone, for joining us today. So just a little background on me and our firm, so I'm a partner (indiscernible). We do research and communication guidance, working closely with advocates and foundations and government entities on a range of issues, often in the realm of social determinants of health, but really focused on equity. And, you know, lots of issues related to housing insecurity, reproductive justice, immigrant justice. A lot of work in the LGBTQ stigma and justice space, but this has been a great project for us to hear directly from

Medicaid beneficiaries and those who are eligible for Medicaid to tell us both what they're experiencing, but also what would help them. And we approached this and all really with Veenu and her team in a very collaborative way to blend quantitative and qualitative research.

So first, we wanted to do in-depth one-on-one interviews so that people could share often very personal, and in some cases really just tragic stories about the challenges they're facing today in just a one-on-one environment and not feel like that they have to share that with a larger focus group audience. But we did also then do focus groups because having that interaction environment can be useful, and people riff off each other and they continue to share very personal stories with each other, but they can also just understand what others are going through. And that was in many ways affirming in some patients and inspiring for them.

As you see on the slide, we did these qualitative interviews and focus groups in

Kentucky, but we also did them in other states: Iowa, Nevada, and New York. And then we got to the survey phase, and for that, at that point, Nevada was no longer part of the research, but we focused on Kentucky and Iowa, and I just want to flag a couple of things. One is we were really sort of treating the survey respondents as part of this across the states, so the survey sample size for Kentucky is perhaps smaller than if we were just doing a survey in Kentucky alone. So we have 253 respondents, and we are able to bring out some results. You'll see summer's results by urban, suburban, and rural which are really constructive, I think. And some results of white residents compared to Kentucky residents of color, but I would just -- I want to just recognize that, you know, ideally we would have a sample where we could really be looking at more closely at certain subgroups, but I think even with the caveats this can be quite instructive. So with that in mind, I will have time for Q&A at the end. I just want to go over some

of the key findings and then some of the details.

So we are seeing that there's really just high social needs among these respondents, and they are very interested, and many of them have taken advantage of a variety of forms of assistance, and it's really just difficulties across social determinants, food, housing, medical care, transportation. And while they face difficulties, there are also challenges about reaching out. Many feel judged or embarrassed. They worry that their kids will be taken away or that they're sort of on that line where, you know, they're making a little bit of money, and they've got some benefits, and they are trying to work. But if they get additional assistance or are able to land a job, then they lose the benefits. So they're trying to navigate that very challenging world.

So for example, this Hispanic woman in Kentucky, she talked about living in a small town and she's a minority. She feels like, "people look at me strange because I'm

Hispanic and I have kids. I know people have stereotypes, like minorities leeching off the government and I feel helpless and vulnerable when I ask for help."

So those concerns are real, and yet at the same time, a strong majority of our respondents have not only reached out for assistance, but they say that the programs that they participated in have been very helpful. And you'll see those results in just a moment.

When we talk about the sorts of solutions that they are looking for, really economic security is at the heart of everything here. It certainly impacts our ability to access food, housing, and transportation. And so the ways in which discounts, etc. -- and I'll show you some of those in a moment -- that's really where the action is in terms of what they're interested in. How can they get opportunities to make ends meet and put food on the table and get where they need to go, and have a safe place to live?

They recognize that they're probably

going to have to be required to share information about the situation in order to get assistance, and there's a lot of concern about sharing information. Both about the kinds of challenges they're facing, but also to certain kinds of people, and I will share results on that in just a moment. But the communication mode matters, and I think to the larger project that Veenu talked about technology. These respondents are very open to using communications that are not always personal. So they like communicating via text, online, e-mail, filling out a form, you know, on a website rather than having to answer questions with a real person on the phone or in person. So they'd also like to have a backup, so that if they have some significant questions about delicate things, they would like to reach out to a person. But for some of that basic information, they're very interested in doing it via technology.

This one gentleman in Kentucky from the focus group said, "I think it's easier when you do it online." When you talk to a

person -- again, going back to the whole stigma thing, I feel like if you are able to do that online, it just makes it less uncomfortable.

So let me dig into some of the detailed findings just overall, and these are just the results for Kentucky I'm focusing on today. About three-quarters said it was at least somewhat hard for them to pay for the very basics like food, housing, medical care, transportation, or heating. And over a quarter, the dark purple, say it's extremely hard to pay for the basics. Another 21 percent say very hard, so that's almost half saying it's very or extremely hard to pay for the basics. These folks are indeed experiencing quite a few challenges. It does vary a little bit by area. So we see more need in urban areas, but especially the rural areas, you see well over 50 percent -- 57 percent combined with the darker purple saying that it's very hard or extremely hard to pay for the basics.

And we see that white respondents are

more likely to report difficulty paying for the basics, especially with the dark purple there. The extremely hard is quite high among white respondents, as well.

We asked a lot of questions about getting assistance and what that experience is like. Most people did say that they had indeed reached out for assistance or support, and that's not always through, say, a government agency or program. They also reach out for support from food banks, family members, from friends, churchgoers, etc. But they do reach out for support when it comes to specific assistance programs, and they actually find it very helpful. And so we see here if you look, again, we focus on the darker colors -- the dark green in this case is the percent of people saying these programs have been very helpful, and we see a very large majority saying section 8 has been very helpful, as well as Medicaid, WIC, SNAP, and other kinds of housing support. So it's nice to see that they reached out for help and were indeed getting the help that they needed.

But reaching out for support triggers shame and worry. We actually see that shame is higher among white respondents. So we have a lot of people of color, as well, reporting that they often feel embarrassed when reaching out, or feel judged, or, as I mentioned before, worrying if they make too much money and they then lose their benefits. And then, you know, we heard some very personal stories in our focus groups and interviews about what it was like worrying as a parent that reaching out for support might mean that their kids will be taken away because of being judged as a bad parent. So these concerns are real, and they are significant barriers to participation.

So now I'm going to go through some of the specific social needs. So I'll start with food. This (indiscernible) out of the housing, transportation, job, education, and other things. First off, we asked two kinds of statements around food insecurity. So we said the two statements that some people have made about their food situation, and

then for each, often true, never true, or sometimes true in the last 12 months. This idea is based on their household -- who is living in their household. I am worried how to find food before we had to find money for more. Look at the dark blue -- about half, and sometimes in the rural areas, more than half of people say that's often true over the last 12 months. Likewise, the food that they bought -- it didn't last, and they didn't have money to get more. Another way that's often asked about food insecurity -- we see similar amounts, so the suburbs seemed to be different. And so, you will see throughout the survey different results.

MS. AULAKH: John, there's one question; someone had said what was the (indiscernible) for people of color versus for whites?

MR. WHALEY: The people of color are in 60, I want to say, and the remaining are white. Also, just breaking out the results by race here. We do see that white respondents were more likely to report having this kind of food insecurity, but

it's very high for both. So when we talk about for each of these solutions, we both asked what the challenges and potential solutions were. So, in this case, we talk about different types of food supports or services that some people feel were helpful and what the respondents would feel these would be to them personally.

So here we see, again, getting discounts on food that they could prepare for themselves at a later time. That would be especially helpful. That's true across this area, but especially in urban areas, and getting discounts on ready-to-eat meals. There's also some interest in free online cooking classes or nutrition coaching, but it's really about getting the discounts that is the highest amount of interest.

We also asked where they reach out if they don't have enough food. And for the most part, asking family members is a frequent option, but also just going to a food pantry or soup kitchen. There's a lot that have been tapping that resource. Skipping meals is often something that they

do, as well, quite frequently, or delaying other expenses.

Getting into housing: We just asked basic questions about their living situation. They have a steady place to live, and we do see, especially in the suburban areas, that a good chunk of respondents do feel that they have a steady place to live. But there are fairly large proportions, also, that might have it today, but they're worried about losing their housing or living situation in the future.

And then we have about 10 to 12 percent or 15 percent rural who do not have a steady place to live, and they may be temporarily staying with others in a hotel, shelter, out on the street, etc.

MS. AULAKH: One more question that came up to me was when you think about how you break down urban versus suburban versus suburb versus rural, can you just say a little bit more about how --

MR. WHALEY: Yeah, and I, too, get asked that. We know this is not -- this is on self-reports. So we tried to describe to

surveying respondents -- I would say that sometimes suburbs can be a little bit tricky because it's in the eye of the beholder. Am I living in a suburb of a large city or not, and sort of the dividing line between, let's say, suburbs and exurbs can be a little bit tricky. So, in this case, we do rely on self-report rather than saying ZIP Code or census blocks.

I would just say, as a rule, that the urban people generally can accurately assess their living in an urban area, and small town or rural is a combination we use. So I think those are generally quite reliable.

We did see people report about the focus groups and the survey that they do have experience with quite a few (indiscernible) and their living situation with water leaks. You see that especially in rural areas, potentially with older living spaces. Over a quarter of rural areas have smoke detectors missing, lack of heat, oven, or stove. You can imagine the challenges that would provide, even though it's a smaller percentage. Lead paint or

pipes is a smaller proportion. Although, again, this is self-reported, so they may or may not know about whether or not they have lead contamination as a problem.

Again, then we talked about solutions. Here are some, you know, housing supports and services, which two or three would be most helpful to them personally. And it's really about financial assistance, paying for utilities (indiscernible). This would likely be somewhat financial assistance, but also it could be some advice about preparing for winter or summer, making their home safer, and cleaning or remodeling for asthma or allergies.

Getting into transportation: We do see that most people say that they have a reliable way to get around. Sort of like their living situation, there are also people that say that they have it now, but they're worried that they may not in the future. And then about, you know, 20 to 25 percent say that they do not have a reliable way to get around, and that certainly impacts their ability to get

places.

So we asked this question: How often do you have to cancel or change your plans or appointments because you don't have access to transportation? About a quarter, especially in urban areas, say very often, but then another 20 to 30 percent say somewhat often. So this is certainly a challenge for many of our respondents in Kentucky.

So when we think about supports and services, again, we see a lot of interest in getting money back for gas, or bus or train fees, or getting discounts on ridesharing services. Just when it comes to ridesharing services, recognizing that many of our rural focus group participants and survey respondents said that is not an option for them in terms of accessing rideshare out in rural areas. That does impact whether or not that would be useful.

Just getting into employment and training as a social need. This is kind of interesting because we do see that a fairly large majority, 74 percent, say that their

current employment situation feels at least somewhat stable. But I would suggest to all of us that when we think about our own personal employment, you really want to feel that that is very stable. Any instability in your employment situation just is hugely problematic, from feeling insecure and feeling very unstable in their employment. And that leaves out a lot of people who can't enjoy that feeling of security.

So we have a few questions about their work. Do they want help finding or keeping their work? And we did see a lot of interest, especially among our people of color in Kentucky wanting help finding work and help keeping work compared to the white respondents, who don't need as much help in terms of finding or keeping work.

In terms of the kinds of support and services that would be helpful when it comes to the employment realm, getting childcare is particularly important. And you do see some major differences here among people of color compared to white respondents with getting childcare, getting assistance,

learning new job skills, and getting assistance finding job opportunities. There's quite a difference there, but about equal when it comes to getting clothing for an interview or job, with about half of white respondents saying that that would be somewhat or very helpful.

And then also, just getting the assistance when applying for jobs. There's a high interest among respondents of color getting assistance creating or updating a resume. Likewise, we see a difference by race there in getting assistance preparing for interviews.

And then, among those who expressed interest in learning new job skills or updating their current job skills, we gave them another list of types of support that would be most helpful, and we saw some real differences by area, which was interesting. So learning new job skills was particularly interesting for suburban respondents and rural respondents. So in rural areas, getting assistance, locating training programs, apprenticeships, or internships.

Suburban respondents were more interested in getting financial assistance to pay for training or education. And then urban and rural were more interested in locating their current job skills pathways.

So the last couple of sections before we wrap and go into Q&A are around how people engage with the process of getting assistance, both in terms of sharing information but also how they would tap technology potentially. So first off, we asked people, you know, when you ask for assistance or support from people, organizations, or agencies, they sometimes request information about you and the challenges you're facing. How comfortable do you feel about sharing information? And so you see very little dark green, very little proportions of people saying they feel very comfortable sharing information about the fact they don't have enough money to buy food and that they're not able to pay for utilities. You see that especially the respondents of color have very low proportions of feeling very comfortable

sharing that information. It certainly relates to some of their concerns in terms of feeling judged or feeling that they may have their children taken away. We have heard those kinds of stories in our focus groups and -- but you see in a number of social needs, a resistance to want to share or discomfort with sharing.

And it also depends on with whom. So we see a little bit more comfort sharing with a health care provider or their staff, although it's not an overwhelming amount of comfort. Someone from a health insurance plan -- the conversations we had in the focus groups around sharing with someone in your church kind of went in two directions. Some people feel very comfortable sharing with their fellow congregants, while others felt very uncomfortable or fear of being judged. So that's an option for some, but not others. But overall here, you just see that there is a discomfort with sharing some of that information.

The mode does matter, as I mentioned. So when we asked this question, you know,

below are some different ways you could communicate with people or organizations providing assistance with things like housing, food, and transportation. Indicate the method of communicating -- if you like this method of communicating or don't like it, or it doesn't make a difference. And see, a lot of people are preferring to interact by e-mail or by filling out a form online, filling out a paper form by themselves that doesn't answer questions over the phone or in person, but you definitely see these differences of communicating. And again, I just want to flag some of the initial information sharing that they like. Electronically, if there are big questions about how to navigate something, they certainly would like to have a human being as an option.

And just finally, we do see even -- I think there are some questions among lower-income adults and their propensity to use technology. And not in this project, but in other projects, we do see with lower income respondents, many of them are relying

heavily on their smartphone to get information, to find work, and to communicate with people about the needs that they have. So smartphones, despite their financial challenges, were something that many of them found a way to pay for because it was just so crucial for them to get by. So just recognizing that this is an online survey, and we certainly do in other projects, there are certain populations, I would say older Hispanics, for example, that generally we would reach out to via phone or other ways, but for many of our respondents, smartphones are a crucial part of their life.

So with that, I'm going to stop sharing. And, Veenu, is there anything that you just want to add before we open it up for questions? And I did see somebody had a hand raised.

MS. AULAKH: Yeah. I mean, I think the issue of trust came up very strongly, and I think when we went in, and especially as we were working with people in some of the other states, as well, there was a sense

it was always the -- your health care provider, or this role. And I think what the research really showed was it's much more about creating that relationship, and it wasn't necessarily a specific title or role. And I think the other thing that surprised us, in a good way, was how comfortable people were, I think, with technology and the role it played in so many aspects of their life, not just health care and how that really translated into the openness. And I think maybe 10 or 15 years ago, we didn't see this in terms of solutions to help support their health. So I think those are just two points that, like, really stood out for us.

MR. WHALEY: And I saw there was a hand up, but I'm not seeing it now. So feel free to unmute -- oh, Patricia, there you are.

MS. BAUTISTA-CERVERA: Thank you. I was just wondering, when you mentioned people of color, particularly Hispanics, do you have any trouble or barriers with language? How did you overcome this? And

I'm representing community-based organizations, so I just wonder how did you manage this? And if you found -- what is the percentage? Of 200 and something individuals from Kentucky that you interviewed, you had access to -- what's the percentage of this population that were Hispanic or had troubles with the language?

MR. WHALEY: Yeah, so I know there was a caveat of the research. Thank you for raising that. This particular survey was done in English. So I just want to call out that for other projects, we do multiple languages. This one was limited in some ways. So I think in terms of, you know, there are certainly populations that we did not tap that we could potentially with an expanded approach, so I think that that's a real just limitation to call out here.

You know, I think in terms of the percentage of Hispanics in this survey, it wasn't especially large, but I think it is also a reflection of Kentucky overall, but I believe it's less than 10 percent of the sample was Hispanic. So I think for -- and

that's why we normally don't like to lump people of color together just to be very blunt. Usually, if we have a large enough sample, and we did in New York, for example. It was a larger state, and we had a larger sample. We have specific subgroups -- by lack of respondents -- Hispanic, etc.

So I do recognize that this particular sample for Kentucky was smaller than we would want to do. If we were only focusing on Kentucky, for example, then we also may want to do multiple languages. So that is something that I know we've talked about with Veenu and her team, about if there were potential gaps we would want to explore.

MS. AULAKH: John, we did do some interviews with Spanish-speaking people in Kentucky in the focus groups, correct?

MR. WHALEY: That's correct. One thing we didn't flag in the survey, but a crucial social need or barrier in that community is immigration status, and it certainly came up in those conversations. So it's often not sort of flagged as one of

the core social determinants of health, and yet, it is absolutely a language barrier. And immigration status are critical challenges for that community, and other communities of color -- and Asian, as well.

MS. BAUTISTA-CERVERA: Thank you. And the main reason for my questioning is because I do agree, you know, it's definitely the tool of choice for the Spanish-speaking community, but if English is the only accessible language, then it's just not possible to jump barriers, but if you are using an interpreter and focus groups then, you know, you go around that. So thank you.

MR. WHALEY: Sure.

MS. BICKERS: And there is a question from Catrena. Did you want to ask --

MS. BOWMAN-THOMAS: Hi. Sure, yes. Catrena Bowman with Northern Kentucky Community Action Commission. We provide a lot of the emergency assistance, so we see exactly what you're talking about. Your results really line up with what we are seeing here in Kentucky. And so, my

question was around the age group with the respondents. Did you have an average age? I was glad to see that so many were comfortable with the technology, so I'm wondering about that -- the age of those that participated.

MR. WHALEY: Thanks for asking that. So we did have -- it was ages 18 to, I think, 64 because we did want to exclude people who were on Medicare or were in retirement or eligible for Medicare, but otherwise, it was a very wide range across that group. I can give you some numbers here if you hold on just a minute. I will pull those up if someone wants to ask -- and Catrena, I am very interested. Can you say more about what you're seeing in your work on the ground when you hear some of the results? I just want to capture some of those details.

MS. BOWMAN-THOMAS: Yeah, sure. So we just finished our community needs assessment. We are here, and the need for food, emergency services, you know, those are at the top of the list. And even with

the job-training piece, really, those top categories are the top categories that we are seeing.

And so I thought it was very interesting about the trust issue. That's something we're trying to figure out and navigate, so I liked -- I hadn't thought about -- I hadn't really talked about the use of more technology to sort of ease some of the uncomfortable feeling with our families. But, you know, when we think about that, we operate the low-income energy assistance program through the state, but, you know, there's a lot of regulations around how we are able to complete those applications and the data that we have to get back. So I think it's good for this information to come into the state level, so as we think about how those programs are structured and the requirements of that, then maybe we can begin to include this thought process of allowing more use of technology so that people are more comfortable and are more willing to receive those benefits.

Because we have some counties, but it's just very difficult to get people to come in for service because of that very thing. They don't want people to know. They don't want to deal with the stigma, and so we have people that are in unsafe situations in their homes because they don't want to seek the services.

So I really appreciate this data. I hope that we can get a result, you know, get a copy of this, and then get a follow-up, too, on your next visit. So thanks for that.

MR. WHALEY: Thank you.

MR. BURKE: Was this information provided -- was this research information provided to all the applicants of the MIC who had put in their submissions and things like that?

MS. AULAKH: Yes. As part of the application process -- it's a big part. The researcher's findings were in that process. And so, yeah, they all had access to it, and in some ways, as we've been going through the process and looking at it and cut out

some of the ones that weren't aligned with what the research findings were showing. So that was an important part of the process.

MR. BURKE: Great.

MS. BOWMAN-THOMAS: One thing I wondered, too, at the beginning, you had told us that separate people -- white people about their comfort level. And I wondered if that is because -- if there's any correlation to having been in that situation if it's the longer you're in the situation. Is that a factor that contributes to if you're comfortable or not? I just wondered that when I looked at that because I was surprised to see the level of difference between those two groups.

MR. WHALEY: I don't know if I have a good answer for that. There are a few results where we did see differences, and it always makes me want to go back in and do additional focus groups to try to explore what you think might be going on there. I don't know. If you have any theories based on your work on the ground, I'd love to hear them.

MS. BOWMAN-THOMAS: No. I think that, just like you said, made me wonder, and that's what one of the first things that came to my mind was when you think about from just what I've seen. You have people of color that are experiencing issues of poverty longer, and so there is not -- so they've sort of gotten a resilience to some of it that someone else that hasn't experienced it as long may not have. And it's not that they don't feel that uneasiness. It's just they've had to become more accustomed to dealing with it is where my thought process went.

MR. WHALEY: Yeah, and I share that hypothesis. I think, you know, for the reason you pointed out, you know, it is a little tricky because it's certainly not because they're experiencing less of a need. We know that not just because of the survey but many other things. I think the historical nature of being really not only the need, but restrained from accessing the help they need and prevented -- so it might just change the perception of it.

As you say, if you've been doing this for decades or generations as opposed to someone who's finding out just now, especially -- we were doing all of this research when inflation was really still quite high. And every focus group I conducted, whether it was on social determinants of health, or any topic, you know, abortion, anything when we asked people about sort of the issues facing them today, it was all about getting food on the table and economic insecurity has been really huge.

MR. BURKE: Part of my question from earlier, and this may be a good question for you, John, or the MAC, or Medicaid might have an answer for it. I was able to evaluate some applications for the MAC, and as you guys presented data, I didn't have this data at my own disposal, so I was wondering, you know, if they had it for their applications? Because as I read the applications, I felt like there were certain areas where I wasn't sure of how they plan to reach all of their, you know, the

Medicaid population was going to be, you know, access the same, you know, whether it would be through different types of media forms. And so when it gets down to just a few applications after they're down to the companies that do plan to -- that Medicaid is going to select because it's going to be a couple of different states together.

We had talked about something like a GARE tool that a lot of Medicaid and the government departments are trying to implement to make sure racial equity and things like that are met whenever they are trying to implement things. I don't know if that's something that the MIC is looking at on their end or who -- once these companies are actually selected if they're going to go back through and try to make sure upon actual implementation if it is done in a more equitable way, or how is that approached?

MS. AULAKH: It's a good question, Jordan. And thinking about -- I think that's going to be definitely a lens just looking at the solutions, and just right now

going through the hundreds of reviews on the solutions. And the comments have come up a lot, you know, how do we make sure that the solutions are -- there are multiple modalities. It's offered in English and Spanish. It's available in rural and, you know, urban and suburban areas, and it's culturally appropriate. Especially around some of the food there's a lot of focus on culturally appropriate foods, and so I think that's going to be a good discussion for this selection committee.

And then, as we think about the pilots and implementation, that's definitely going to be a big part of the discussion. We hadn't thought about it in the context of looking at the GARE tool, but that might be a good framework for us to go back to to make sure it ties back to some of those elements you all are thinking about. So thanks for that information.

MR. BURKE: Yeah. I know -- I am not sure the best way to implement it because you're working with, I presume, essentially private companies being paired with

Medicaid. So I don't know how you could recommend that they do it, but if you're pairing with them and you've already selected them, it's a very, you know, similar --

MS. AULAKH: Yeah. I think it'll be a good question. So, you know, we're doing the showcases at the end of May, and then we're going into another one around infrastructure at the end of June. I think these will be good questions we can ask the companies. They might be good standard questions we ask all the companies. As you think about the implementation, how do you ensure you do it in an equitable way? Just seeing how they respond, so that might help us figure out --

MR. BURKE: As Dr. Bautista said, with the information they said in this form, which is based on an English survey. Great. That's fantastic. We selected patients, but at the end of the day, when it's implemented, it's going to involve patients that weren't selected within the survey, whether that's because they aren't

English-speaking or things like that. So how do we make sure, before it's implemented, we think about those patients, too?

MS. AULAKH: Yeah. Really good point.

MS. RICHERSON: I would just add to that. When you start thinking about -- I'm in Louisville, Kentucky. It has one of the largest refugee resettlement programs in the country. We have a very large immigrant population in addition to the refugees. Every part of the state is unique, and there is no typical, right? And these surveys didn't necessarily take into account the children that are on Medicaid. These are just adults receiving Medicaid. So there are a lot of children who receive Medicaid whose parents don't receive Medicaid. So getting -- you don't -- that's a whole big population that is not accounted for in this data.

So I just wanted to make those comments. That's what's going through my mind. How is something implemented that is

really effective when we've got to take so many things into account?

MS. BAUTISTA-CERVERA: I'm going back into what Dr. Richerson just shared. You know, many of these parents of Medicaid-eligible kids are not even able to read or write. It doesn't matter if they speak Vietnamese, or Swahili, or Spanish. Without a doubt, the smartphone is the tool of choice. But when I think of the communities that we are able to accompany -- what Catrena Bowman just shared is the need for the very basics. And what your program -- or your study just demonstrated, is the pure basic coverage of needs for all across food, housing, and transportation. And it's for all colors, all languages, and all ages. And thank you for doing this, but just like Dr. Richerson said, there's a big population that is not being taken into account.

MR. WHALEY: Right. And we did -- so we included -- again, so it's all adults for sure, but we did include both Medicaid beneficiaries and those who are eligible for Medicaid based on their income and household

size. So we had sort of a formula to include them in the survey, and we did ask if their children were on Medicaid, as well. But we certainly did not delve into specific challenges for their children, outside of our family did not have enough food to eat or these were the things affecting our home.

Certainly, that is a population that would need to be taken -- our focus groups, we also showed them, have websites or other kinds of navigational hubs that they can look to. And there are certainly things to look at for their families, as well as for themselves.

Just to Dr. Richerson's point around different communities, it is so important that the resources look like they are speaking to all sorts of communities. It really helps to credential the resources as inclusive, and it doesn't always matter if it's for a viewer's own community. People across races and experiences want to see that other people are included, as well. It really does provide a level of expertise and credibility, so there's sort of a

two-for-one win when you can both speak to the people who need it directly, but also indicate to everyone that you are reaching out to multiple communities and languages.

We have a focus group respondent -- I can't remember what hub, whether it was findhelp.org, but he saw they had Haitian Creole as a language option, which was, you know, his parents had immigrated from Haiti, and it was so important for him to see, but the other focus group participants who were not Haitian were so happy that that was there. Like, these people really know what they're doing, so it's just interesting how that can work on both levels.

MR. BURKE: Thank you, guys. Does anyone else have questions for John and Veenu?

(No response.)

MR. BURKE: Awesome.

MS. BOWMAN-THOMAS: What did you say is your next step? I know you're compiling the data or compiling --

MS. AULAKH: The solution. So that data helps inform the call for applications.

And so now we have the 106 applications that came in, and we're having a managed care plan, state Medicaid, and we have consumer people in Medicaid reviewing the applications. And we are having our selection committee meeting next week, and then we'll be showcasing the finalists at the end of May. And then, with the hope that out of those finalists, there will be some that the states in the managed care plans are interested in piloting and implementing in the community.

MR. BURKE: Thanks again, guys.

MS. AULAKH: All right. Thanks, Jordan.

MR. WHALEY: Nice meeting you all. Thanks for the opportunity.

MR. BURKE: Thank you, John. Thank you, Veenu.

A couple more things, the only thing really we didn't get to touch on old business is something that I believe it was Angie Parker who had mentioned. She had just brought up if there's any, you know, reports that kind of help highlight any

health disparities that we haven't recognized, that would be something we would be able to look at and review. Whether you have something currently to talk about today or if it's something you just want to send out. I know that the minority health report -- I just didn't know if you guys had any type of data that the TAC might be able to review.

MS. PARKER: Not today. This is Angie Parker.

MR. BURKE: Yeah.

MS. PARKER: That is something that we are looking at developing with the MCOs.

MR. BURKE: Okay. All right. Leslie, did you say that you wanted to mention something about the way --

MS. HOFFMANN: Yeah, it's actually a new business item. I think it's -- so can I share, Kelli? Can you let me be a sharer, please?

MS. SHEETS: Yes, ma'am, I will.

MS. HOFFMANN: I just thought I would give you all the information I've been giving at all the MCO forums. Just a

second. Can you see my screen?

MS. SHEETS: Yes.

MS. HOFFMANN: Going from Zoom to Teams -- I have to make sure I'm doing it correctly. So we have a lot of behavioral health initiatives, and currently, one of them is the SMI application. So I wanted to talk just a little bit about that.

It started out really as an adventure, working towards parity and assisting with severe mental illness needs. However, as we kind of got along with that, more and more social determinants of health-related activities came about, and so we started addressing those.

So here you'll see a semi-severe mental illness. Just remember, this is a play on words. You will also hear us say serious mental illness sometimes, and that's just a play on words of how or what opportunity DMS is offering at the time.

These are just some things that I wanted to let you know about in the 1115 overview. First of all, I know there are a lot of acronyms that we say constantly every

day, so I wanted to just say what is an 1115? It's just a number probably, but an 1115 is a process or a task that allows DMS to give us the authority to do experimental or pilot, or demonstration projects. Kind of thinking outside the box with lots of flexibilities, and it allows us to quote waive requirements that DMS or Medicaid has.

So we can look at this population. Now, I will tell you, there's a lot of responsibility here. We have to show them that we're providing services with a better quality of life and equal to or less than the cost that we would have with the services that they already had approved. So just remember, we're asking them to waive the rules. And then, we have to prove to them that these folks are going to have a better quality of life if they will allow us to do this demonstration.

Some of the things that we're looking at right now are recuperative care. You may have heard this mentioned in the medical world as medical respite. It's for lack of a better explanation, it's like an acute or

post-acute situation where maybe a person is homeless and needs a place to stay to recuperate, or this can be pre or post-operational kind of things that go on. For example, a colonoscopy might have pre-op stuff that you need to do before you go in. Maybe you've got something that you've had done, and you have wound care, and you need a safe, clean place to stay and you're homeless. So this is an opportunity to rest, heal, and recover in a safe environment. So again, you will see this in the federal world, also mentioned as medical respite.

Expansion of IMD: We're very proud of this. We're trying to meet the parity of what we recently or a couple of years ago did on the SUD side. We want to expand days of stay beyond 15 days, and we have to keep an average stay of 30 days. So this would be in-patient care. And IMD stands for Institutions for Mental Disease. So these are facilities that primarily serve behavioral health, mental, and substance use together, and that's what we're trying to

do.

So this is very exciting, and this also allows me, like a domino effect, to assist with what we call Money Follows the Person. When a patient transitions out of IMD -- those facilities have never been allowed to do that, so this -- if we get this waived, then we can go back and see if we can move people out of IMDs through the Money Follows the Person process. Now, I know that's a lot of acronyms again.

I'm very proud to say that the public comment for this waiver has already been posted. It will be out there for two more days on the website. Our comments and responses back, and then back to DMS, will be around 5/31. That's the projected date. We completed three forums -- town hall meetings to talk about this amendment, and those have been completed. So I just wanted to share that with you.

And then, I wanted to share this. So along with what I just talked about, the 1115 waiver, we are also submitting in conjunction, and collaboration -- and

partnership, however you want to think about it. Two waivers are going to come together and try to form a cohesive model that can try to fill the gaps. So we're also asking for a Kentucky 1915(i) SPA, which, again, I know that's a bunch of numbers. The best way to think about this is trying to figure out how to do some all-inclusive measures for folks. We are looking at social determinants of health and supported employment, supported housing, and behavioral health respite.

So our intent through Senate Joint Resolution 72 would be to allow for somebody coming out of an IMD that needs a transitioning place to go, maybe somebody who needs a three-person staff to residence-type of look, all the way up to the folks that just need some supportive services provided at the location. So this is your full spectrum. I don't know how else to say it. I keep seeing it on this rainbow spectrum here. It's going to be a lot of -- an array of services that might be needed. If you're looking for some

supported employment through IPS or Individual Placement Model of Supported Employment. We have currently been working with (indiscernible) to see if we could get this worked out for people with serious mental illness.

We are also working, like I said before, on the supportive housing, which will have a wide range of services. And then behavioral health respite, but it is really for the caregiver for time away. But it's those situations where you might see a crisis that's about to occur, but a couple of hours away for that person to be separated, maybe from the family member they're arguing with, might be all they needed, and that way, we can divert from inappropriate placements or settings, such as hospitals or incarcerations unfortunately sometimes.

You all are aware, also -- I'm going to quit sharing. Hang on a minute, one more thing. Let's see -- I can share this later, too. This is our DMS homepage, where the things are posted if you wanted to read

them. The DMS behavioral health page and DMS issues. This box here, the DMS.issues -- that KY is specific for behavioral health, but if you sent something there, it's okay. One of our subject matter experts will pick it up and send it out to the correct folks. So also -- I'm going to stop sharing.

So you've heard me talk about our mobile crisis intervention, which is very exciting. And that's also going to serve any population at any time, whether you are Medicaid insured, uninsured, third-party, whatever the reason or payment model is. We also have a lot more things going on with mobile that I can share with you later, but we also want to identify the crisis and the appropriate response. Whether it be LGBTQ or elderly with dementia. Whether the appropriate response for the crisis need is where we want to go, and we're partnering with our sister agencies on this, so it's very exciting. We currently have a proposal out right now for mobile crisis, so we're very excited about that, too.

So just telling you all the things that we've got going on. Jodi Allen might be on here with me. She's kind of been with me on this, and we are just continuing to work more and more toward social determinants of health. How we can address it? How we address it appropriately? How we can divert (indiscernible)? So it's very exciting right now, and there's other things that are coming down the pipe, like food as a social determinant of health and other opportunities that we may have very, very soon to take a look at. So we're really trying to get what we've got going, and then we can take a look at other future goals after that.

That was a lot, and I'm sorry, Jordan.

MR. BURKE: No, that's okay. Catrena asked in the chat real quick, and I'll try to wrap everything up. She said, "Are you identifying partners to assist with the social determinants of health?"

MS. HOFFMANN: So we've been working in collaboration with the housing authority

for the homeless population, and we have been, for the first time ever, able to connect HMIS data, which is housing data, to our populations. We've never been able to do that, and with the approval of our cabinet, we were able to get Jodi Allen as an actual user of HMIS data, so that's very exciting for us. We can actually go in now and match up Medicaid members with the homeless population. We've never been able to do that before, so that's very exciting.

MR. BURKE: Great.

MS. HOFFMANN: And when we say "we," I mean Medicaid, and the Department for Behavioral Health has had other initiatives along the way. I don't want to discredit anything they have done, but we have never been able to do that.

MS. BOWMAN-THOMAS: I think that's going to be a critical part of this success of everything that you've got going on. What sounds really great is that you really look at community partners that are active in those spaces to partner with.

MS. HOFFMANN: Yes.

MS. BOWMAN-THOMAS: So you're not trying to take on pieces that's not in your expertise, but lean on those -- all those partners that have the expertise to --

MS. HOFFMANN: I think that's one of the big things. With the applications I've seen and the MCOs -- or from the MCOs are trying to pair with community-based organizations that are already out there. Not trying to invent the wheel, but trying to help, you know, merge together to provide better care from both ends and to kind of get the whole community involved from all aspects. So, yeah --

MR. BURKE: Right.

MS. HOFFMANN: And we are not letting anything go. We're trying to expand on what we have and what's working and identify gaps, so yes. Thank you.

MR. BURKE: So, thanks. We didn't get to the Medicaid organizational chart, whether that's something that you had done between the last meeting and now. We can look at it next time or if it's something you just wanted to send out. If you had

some stuff to talk about, we can wait until next time.

MS. HOFFMANN: If that's just the most recent Medicaid organizational chart, I think, Kelli, do you have that available where you can send it out or get it?

MS. SHEETS: I can send it out. I'd be happy to do that.

MS. HOFFMANN: I think she can go ahead and do that.

MR. BURKE: Great. We'll be able to look through that, and then, if we have questions, we can bring it up next time.

Jodi had said something in the chat -- engagement also makes great (indiscernible.)

So, yes. I think we weren't able to establish a quorum. So I believe that means we don't get to vote on any recommendations either. So no recommendations we can make for the MAC. I'll attend the next meeting -- attend, I guess, in terms of sharing, at the very least, by default. And we'll close out if there are no other questions and nothing else anybody needs. Thanks for

coming, guys.

(Meeting adjourned at 3:07 p.m.)

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CERTIFICATE

I, Tiffany Felts, CVR, Certified Verbatim Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 20th day of May, 2023.

Tiffany Felts, CVR

Tiffany Felts, CVR